MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01762 — 01754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Meady	Middle: Melinda Appold	Last	2a. DATE OF DEATH Month: 2 Day: 5 Year: 1969		2b. HOUR: 6:25 M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 1-29-1884	6. AGE (In years last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): W.Va.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Sylvan Retreat	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: Rt. #1 Valley Rd.	
14. FATHER'S NAME First: Joseph	Middle: Wagner	Last	15. MOTHER'S MAIDEN NAME First: Emily	Middle	Last: Kerns
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No. (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Herman F. Appold	Address: 406 Williamson St. Versailles, Mo.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): C V A

DUE TO, OR AS A CONSEQUENCE OF

(b): Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4369

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospitol) attended the deceased from 11 5, 1960, to 2 5, 1969, that (I) (we) last saw the deceased alive on 11 4 1969, and that in (my) (aur) apinian death occurred an the dote and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: George M Simons	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 11/6/69	
22d. PHYSICIAN'S NAME (Type): George M. Simons	22e. ADDRESS: Memorial Hosp. Cumb. Md		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/7/69	23c. NAME OF CEMETERY OR CREMATORY: Wagner Cemetery	23d. LOCATION (City or Town) (County) (State): Dan Run, Mineral, W.Va.
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: FEB 10 1969	25b. REGISTRAR'S SIGNATURE: Wilmer Cross

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01763 01755

1

1. DECEASED-NAME (Type or print): First PEARL Middle E. Last BARTLETT
2a. DATE OF DEATH: Month FEBRUARY Day 8, Year 1969
2b. HOUR: 9:00 PM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: 7-13-1901
6. AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VA.
13b. COUNTY: MINERAL
13c. CITY OR TOWN: RIDGELEY
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: RT. 1 Short Gap, W. Va.
14. FATHER'S NAME First PHILIP Middle Last DICKEL
15. MOTHER'S MAIDEN NAME First NELLIE Middle M. Last BLANK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY Ooccurred (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 2-4-69, 19___, to 2-8-69 19___, that (I) (we) last saw the deceased alive on 2-8-69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 2/7/69
22d. PHYSICIAN'S NAME (Type): DR. R.J.WMS.
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb.10,1969
23c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery
23d. LOCATION (City or Town) (County) (State): Springfield , Ohio
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: FEB 10 1969
25b. REGISTRAR'S SIGNATURE: [illegible] Under

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

FOR STATE HEALTH DEPT.

Item6 FilmG410 3/6/69kl 01764

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01756

1. DECEASED-NAME (Type or Print) First	Middle	Lost
Agnes		Bell

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: Feb. 27, 1969 — 2b. HOUR: 12:20 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Female	White	3/2/1890	68 78 YRS.				

2c. DATE PRONOUNCED DEAD: Month Day Year: February 27, 1969 — 2d. HOUR: 12:20 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MD.	USA.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	NONE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	Allegany	Lonaconing	YES [X] NO [ ]	2 East Main St.

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Thomas		Bell	Margaret		Mc Millian

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	215-50-4368	Mrs. Mary Stevens (Sister)	La Vale, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) BODY BURNS (75%) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 Hours

DUE TO, OR AS A CONSEQUENCE OF

(b) (conflagration at home) — 24 Hours

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 890X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
1	:00 ~~P.M.~~ Feb. 26 19 69	Caught fire while sitting in front of stove.

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
	Home	3 East Main St. Lonaconing, Alleg. Maryland

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: February 27, 1969

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3/2/1969	Oak Hill Cemetery	Lonaconing, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn Lonaconing, Md.	MAR 4 1969	J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01765 01757

1. DECEASED-NAME (Type or print): First JOSEPH Middle STUDHAM Last BEWICK SR.

2a. DATE OF DEATH: Month 2 Day 16 Year 69

2b. HOUR: 12:10 P M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: 1-3-76

6. AGE (In years last birthday): 93 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (State or foreign country): ENGLAND

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: ALLEGANY Md

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED

12b. KIND OF BUSINESS OR INDUSTRY:

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: CUMBERLAND

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 801 SHRIVER AVENUE

14. FATHER'S NAME First JOSEPH Middle Last BEWICK

15. MOTHER'S MAIDEN NAME First MARGARET Middle Last (Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO. 169-05-5990

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — Approximate interval between onset and death: Acute

4109 Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Myocarditis & Decompensation — 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — 5 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from June, 19 64 to Feb 16, 19 69, that (I) (we) last saw the deceased alive on Feb 16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Chas B Durrett DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 2/17/69

22d. PHYSICIAN'S NAME (Type): DR. C. DURRETT

22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2/19/1969

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City or Town) (County) (State): Cumberland Alleg Md.

24. FUNERAL DIRECTOR: John J. Hafer, Jr. ADDRESS: 230 Balto Ave. Cumberland, Md.

25a. REC'D BY REGISTRAR: FEB 19 1969

25b. REGISTRAR'S SIGNATURE: Clinton Yeager

Item 21b Film 409
2-18-69 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01766 — 01758

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
	GEORGE	R.	BIDDINGTON	Feb. 2, 1969	11a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
MALE	WHITE	DEC. 15, 1883	85 YRS.			February 2, 1969	11a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	TAILOR	SELF-EMPLOYED

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES [X] NO [ ]	W. MAIN STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ROBERT		BIDDINGTON	MARY		ROBB

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
2	212-32-8098-A	MISS MARY HANSON, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stoting the underlying couse last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
887X	IMMEDIATE CAUSE (a) Pulmonary Embolism	Sudden
	DUE TO, OR AS A CONSEQUENCE OF (b) Fracture Left Femur	9 days
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)
	3:00 P.M. Jan. 24 Feb. 2 1969	Fell while walking

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
	Nursing Home Grounds	Near Grantsville, Garrett, Maryland

22a. **I certify** thot I took chorge of the remoins described above, held on Autopsy [X], Inspection [X], Inquiry [X], ond in my opinion death resulted from: Naturol couses [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined monner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic M.D. / BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS(Street, city, town, or county): CUMBERLAND, MARYLAND

22b. DATE SIGNED: February 2, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2-4-69	FBG. MEMORIAL PARK	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	FEB 5 1969	

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01767 — 01759

1

1. DECEASED-NAME (Type or print): First WALTER; Middle FRANKLIN; Last BLANK
2a. DATE OF DEATH: FEB. Month 9 Day 1969 Year
2b. HOUR: M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: NOV. 22, 1888
6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CUMBERLAND NURSING HOME
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): FOREMEN - UNION MINING COMPANY
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: MT. SAVAGE
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: NEW ROW
14. FATHER'S NAME First: LEVI; Middle; Last: BLANK
15. MOTHER'S MAIDEN NAME First: FANNY; Middle; Last: WILHEIM
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 214-01-0168
17. INFORMANT Address: MRS. ROSE TUTTLE, MT. STORM, W. VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of the lungs — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 3-2-, 1968, to 3-9-, 1969, that (I) (we) last saw the deceased alive on 2-8- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: G. Brings DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [ ]
22c. DATE SIGNED: 2-10-69
22d. PHYSICIAN'S NAME (Type): LEWIS BRINGS, M. D.
22e. ADDRESS: 57 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: FEB. 12, 1969
23c. NAME OF CEMETERY OR CREMATORY: METHODIST CEMETERY
23d. LOCATION (City or Town) (County) (State): MT. SAVAGE, MD.
24. FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, FROSTBURG, MD.
25a. REC'D BY REGISTRAR DATE: FEB 13 1969
25b. REGISTRAR'S SIGNATURE: Charles Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01768 01760

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JEROME	Middle: HUBERT	Last: BOCK	2a. DATE OF DEATH: 2 Month 10 Day 69 Year	2b. HOUR: 4:40 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-8-10	6. AGE (In years last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: US OF A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED PLUMBER	12b. KIND OF BUSINESS OR INDUSTRY: PLUMBING			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VA.	13b. COUNTY: MINERAL	13c. CITY OR TOWN: RIDGELEY	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 12 JONES ST.		
14. FATHER'S NAME: First LEONARD Middle JOSEPH Last BOCK	15. MOTHER'S MAIDEN NAME: First (STARNER) CHARLOTTE Middle Last BOCK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 221-10-0327	17. INFORMANT: HOSPITAL RECORDS	Address: 900 SETON DR. CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cancer of Lung Right Inguinal and — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO, OR AS A CONSEQUENCE OF (b): of mediastinum

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1701

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 65, to Feb 14, 1969, that (I) (we) last saw the deceased alive on Feb 14 19 69 and that in (my) (our) opinion death occurred on the date and haur and fram the couses stoted above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] 22c. DATE SIGNED: 2/14/69

22d. PHYSICIAN'S NAME (Type): BLANE M. SCHINDLER 22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/13/69	Zion Memorial Park,	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD. 25a. RECD BY REGISTRAR DATE: FEB 14 1969 25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01769 01761

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: HELEN	Middle: Louise	Last: BRANSON	2a. DATE OF DEATH Month: 2	Day: 27	Year: 69	2b. HOUR: 12:10 P M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 7-8-06	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Seamstress	12b. KIND OF BUSINESS OR INDUSTRY: Clothing Mfr.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RT. 5, FAIRGO			
14. FATHER'S NAME First: Charles H.	Middle:	Last: Leslie	15. MOTHER'S MAIDEN NAME First: Pearl	Middle:	Last: Reynolds		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-36-6459	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO, OR AS A CONSEQUENCE OF

(b): Adenocarcinoma Breast — 3 years

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from January, 1969, to 27 Feb. 1969, that (I) (we) last saw the deceased alive on 27 Feb. 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: F. Miltenberger M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 2 Mar 69

22d. PHYSICIAN'S NAME (Type): DR. F. MILTENBERGER

22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Mar. 2, 1969	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town): Cumberland	(County): Allegany (State): Md.

24. FUNERAL DIRECTOR ADDRESS: H. Wayne George, 202 Greene St. Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAR 4 1969

25b. REGISTRAR'S SIGNATURE: Juanita Judge

VR A15 (1) 45M - 1-68

9 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M - 1-69

01770

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01762

1. DECEASED-NAME (Type or print)	First: JOHN	Middle: WILLIAM	Last: BRODE	2a. DATE OF DEATH Month: 2 Day: 4 Year: 69	2b. HOUR: 10:40 A.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: DECEMBER 09, 1912	6. AGE (In years last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): COUNTY ROADS OFFICE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RFD. 1, BOX 551		
14. FATHER'S NAME First: PHILLIP	Middle	Last: BRODE	15. MOTHER'S MAIDEN NAME First: ELIZABETH	Middle	Last: SLEEMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown: YES	(If yes give war or dates of service): ?	16b. SOCIAL SECURITY NO.: 218-16-3589	17. INFORMANT Address: HOSPITAL RECORD, 900 SETON DR., CUMB., MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of pancreas with metastises

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 157.9

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from 10 JAN, 1969, to 4 Feb, 1969, that (I) (~~we~~) last saw the deceased alive on 4 Feb 1969, and that in (my) (~~our~~) opinion death occurred an the date and hour and from the couses stoted abave, (I) (~~we~~) (~~did~~) (did not) view the body after deoth.

22b. SIGNATURE: Andrew Stasko M.D. DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 4 Feb 69	
22d. PHYSICIAN'S NAME (Type): ANDREW STASKO, M.D.	22e. ADDRESS: 401 DECATUR ST., CUMBERLAND, MD. 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 2-7-69	23c. NAME OF CEMETERY OR CREMATORY: F(BG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (Stote): FROSTBURG, ALLEGANY, MD.	
24. FUNERAL DIRECTOR: DURST FUNERAL HOMES	ADDRESS: 57 FROST AVE., FROSTBURG, MD. 21532	25a. REC'D BY REGISTRAR DATE: FEB 10 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

JOHN WILLIAM BRODE 2 M CS 10:40

MALE WHITE DECEMBER 09, 1912 56

MARYLAND USA X ALLEGANY

CUMBERLAND SACRED HEART HOSPITAL COUNTY ROADS OFFICE

MARYLAND ALLEGANY FROSTBURG X RFD. 1, BOX 551

PHILLIP BRODE ELIZABETH SLEEMAN

YES 218-16-3589 HOSPITAL RECORD, 900 SETON DR., CUMB., MD.

ANDREW STASKO, M.D. 401 DECATUR ST., CUMBERLAND, MD. 21502

DURST FUNERAL HOME&, 57 FROST AVE., FROSTBURG, MD. 21532

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01771 — 01763

1. DECEASED-NAME (Type or Print)	First: Robert	Middle: M.	Last: Castleman	2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ]	Month Day Year: FEB. 12, 1969	2b. HOUR: 12:15 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Oct. 5, 1894	6. AGE (In years last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: FEBRUARY 12 1969	2d. HOUR: 12:20 AM
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Conductor	12b. KIND OF BUSINESS OR INDUSTRY: Railroad				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 8 Virginia Ave.			
14. FATHER'S NAME First: James	Middle: H.	Last: Castleman	15. MOTHER'S MAIDEN NAME First: Sarah	Middle: M.	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): War I	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mrs. Edith Castleman,	ADDRESS: Cumberland, Md. Wife				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) CORONARY THROMBOSIS — 〃

DUE TO, OR AS A CONSEQUENCE OF

(c) CORONARY SCLEROSIS — --〃----

Conditians, if any, which gave rise to immediate cause (a), stoting the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy [ ], Inspectian [X], Inquiry [X], and in my apinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: February 12, 1969

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

ADDRESS(Street, city, town, or co): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY DR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 14, 1969	Davis Memorial Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	FEB 14 1969	

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

01772 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 01764

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First: Rodney	Middle: Cedric	Last: Cleggett	2a. DATE KNOWN OF DEATH XX Month Day Year / ESTIMATED ☐: FEB. 11, 1969	2b. HOUR: 8:35a M	
3. SEX: Male	4. RACE: Colored	5. DATE OF BIRTH: Nov. 3, 1968	6. AGE (in years last birthday): 3mo — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year: FEBRUARY 11, 1969	2d. HOUR: 19 8:35a M
7a. BIRTHPLACE (State or foreign country): Cumberland Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Cumberland Md	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL-DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 928 Glenwood Street.	
14. FATHER'S NAME First: Robert	Middle: William	Last: Cleggett	15. MOTHER'S MAIDEN NAME First: Mary Lee	Middle: Harvey	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Mr. Robert W. Cleggett	ADDRESS: Cumberland Md.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE PULMONARY EDEMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1-2 Hours
DUE TO, OR AS A CONSEQUENCE OF
(b): CONGENITAL HEART DISEASE — -------
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7469

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX
22b. DATE SIGNED: February 11, 1969
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/13/69	23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR: Louis Stein Inc.	ADDRESS: Louis Stein Inc. Cumberland Md.	25a. REC'D BY REGISTRAR DATE: FEB 13 1969	25b. REGISTRAR'S SIGNATURE	

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01773 — 01765

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01
1

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Railroad Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. STREET ADDRESS: Railroad Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EFFIE		CORRIGAN	2/2/1969		19

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		8/14/1898	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Gilmore, Md.	USA.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Duckworth	Rachael Beeman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		(Husband) Frank Corrigan, Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO (b)	Coronary Sclerosis	---
DUE TO (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelis M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Cumberland, Maryland
22. DATE SIGNED: 2/2/1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/4/1969	Laurel Hill Cemetery	Moscow, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn Lonaconing, Md.	FEB 7 1969	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01774 01766

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
30M REV. 1-68

1. DECEASED-NAME (Type or print)	First: Elizabeth	Middle: B.	Last: Corstorphine	2a. DATE OF DEATH: Month Feb. Day 23 Year 1969	2b. HOUR: 2:50 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 9/30/84	6. AGE (In years lost birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Scotland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sylvan Retreat	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Sales Clerk	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Lonaconing	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: Park Place		
14. FATHER'S NAME First: George	Middle	Last: Corstorphine	15. MOTHER'S MAIDEN NAME First: Margaret	Middle	Last: Blackburn	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-03-2043-A	17. INFORMANT: "Nephew"	Address: George Gardner Lonaconing, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial infarction, Ischemic — Approx. 5hrs

DUE TO, OR AS A CONSEQUENCE OF (b): Chr. ASHD & P.A.B. — many years

DUE TO, OR AS A CONSEQUENCE OF (c): Gen. Arteriosclerosis — many years

4123

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Inter-trochanteric Fx. (R) 10/31/68 — Senility & cerebral deterioration

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / Stote

22a. **I certify** that (I) (this hospital) attended the deceased from April 15, 1967, to Feb. 23, 1969, thot (I) (we) last saw the deceased alive on Feb. 22 1969, and that in (my) (our) opinion deoth occurred on the dote ond hour ond from the causes stated above, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE: John A Topper MD	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑	22c. DATE SIGNED: 2-25-69	
22d. PHYSICIAN'S NAME (Type): John A Topper MD	22e. ADDRESS: Memorial Hospital Cumberland Md		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/25/69	23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery	23d. LOCATION (City or Town): Lonaconing	(County): A.	(State): Md
24. FUNERAL DIRECTOR: George Eichhorn	ADDRESS: Lonaconing, Md.	25a. REC'D BY REGISTRAR DATE: FEB 26 1969	25b. REGISTRAR'S SIGNATURE: Alexander Judge		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01775 Item6 Film G410 3/6/69 kk

01767

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: SAMUEL	Middle: WEBSTER	Lost: CROWE	2a. DATE OF DEATH: Month 2 Day 23 Year 69	2b. HOUR: 10:20 A M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-21-99	6. AGE (In yeors last birthday): 69 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (Stote or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED-GARRET CO. RD. COMM.	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: LONACONING	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Route 1, Lonaconing, Md.	
14. FATHER'S NAME First: ~~STEWART~~ HENRY	Middle: STEWART	Lost: CROWE	15. MOTHER'S MAIDEN NAME First: (DUCKWORTH) LEVINA	Middle	Lost: CROWE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213 18 2708	17. INFORMANT: HOSPITAL RECORD	Address: 900 SETON DRIVE CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of Pancreas — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

1579

Conditions, if any, which gove rise to immediote couse (a), stoting the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While ot work [ ] Not while ot work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22a. **I certify** that (I) (this haspital) attended the deceased fram _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Michael Glick	MD DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 2-26-69
22d. PHYSICIAN'S NAME (Type): MICHAEL GLICK M.D.		22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/26/1969	23c. NAME OF CEMETERY OR CREMATORY: Trinity Methodist Cemetery	23d. LOCATION (City or Town) (County) (Stote): New Germany Garrett Md	
24. FUNERAL DIRECTOR: HAFER'S FUNERAL HOME	ADDRESS: FROSTBURG, MD.	25a. REC'D BY REGISTRAR DATE: FEB 28 1969	25b. REGISTRAR'S SIGNATURE: J Charles Judge	

VR A15 M
30M REV. 1-68

SAMUEL WEBSTER CROWE 2 23 69 10:20

MALE WHITE 2-21-20 69

X

MARYLAND [illegible] ALLEGANY

CUMBERLAND SACRED HEART HOSP. RETIRED-GARRET CO. RD. COMM.

MARYLAND ALLEGANY LONACONING X

STEWART CROWE (DUCKWORTH) LEVINA CROWE

MD 213 19 2720 HOSPITAL RECORD 909 SETON DRIVE CUMBERLAND, MD.

MICHAEL GLICK M.D. 312 SETON DRIVE, CUMBERLAND, MD.

HAFER'S FUNERAL HOME FROSTBURG, MD.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01776 — 01768

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Rose	Middle:	Last: Cullen	2a. DATE OF DEATH — Month: February Day: 25, Year: 1969 @ 8:50 P.M.	2b. HOUR: P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 4/10/1906	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany County Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Frostburg	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER	
14. FATHER'S NAME — First: Thomas	Middle:	Last: Hughes	15. MOTHER'S MAIDEN NAME — First: Bessie	Middle:	Last: Harden
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: P.O.Box 599, Allegany County Infirmary records.	Address: Cumberland, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): acute upper gastro intestinal tract hemorrhage = 1dy — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): acute hepatic insufficiency — approx 12dys

DUE TO, OR AS A CONSEQUENCE OF (c): Parkinson's Disease — many years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 342X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Ca. Cervix, edema, anuria.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I **certify** thot (I) (this hospital) attended the deceased from Feb. 25, 1941, to Feb. 25, 1969, that (I) (we) lost saw the deceased alive on Feb. 25, 1969, and that in (my) (aur) apinian death accurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE: John A. Hopper MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 2-27-69		
22d. PHYSICIAN'S NAME (Type): John A. Hopper MD	22e. ADDRESS: Memorial Hospital, Cumberland, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/28/1969	23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery	23d. LOCATION (City or Town) (County) (State): Lonaconing, Md.	
24. FUNERAL DIRECTOR: George Eichhorn	ADDRESS: Lonaconing, Md.	25a. REC'D BY REGISTRAR DATE: MAR 4 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Judge	

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01777 — 01769

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type ar print)	First: ~~BABY~~ DEBRA	Middle: ~~BOY~~ KAY	Last: DAYTON	2a. DATE OF DEATH Month: 02	Day: 21	Year: 69	2b. HOUR: 10:00A	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-21-69	6. AGE (In years last birthday) YRS. —	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS 06 / MIN. 23			
7a. BIRTHPLACE (State ar foreign country) CUMBERLAND,	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.					
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY: NONE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER				
14. FATHER'S NAME First: ALBERT	Middle: LEE	Last: DAYTON	15. MOTHER'S MAIDEN NAME First: DONNA	Middle: JEAN	Last: SELF			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service) —	16b. SOCIAL SECURITY NO.: None.	17. INFORMANT: Sacred Heart Hosp. Records	Address				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia
DUE TO, OR AS A CONSEQUENCE OF (b): Prematurity
DUE TO, OR AS A CONSEQUENCE OF (c): —
Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last. 7769
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature af injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Nat while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. Na. City ar Tawn Caunty State

22a. **I certify** that (I) (this hospital) attended the deceased from 02-21, 1969, ta 02-21, 1969, that (I) (we) last saw the deceased alive an 02-21 1969, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated above, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Robert D. Madell M.D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/10/69	23c. NAME OF CEMETERY OR CREMATORY Allegany Co. Cem.	23d. LOCATION (City ar Tawn) Cumberland	(Caunty) Allegany (State) Md.
24. FUNERAL DIRECTOR: Louis Stein Inc.	ADDRESS: Cumb. Md.	25a. REC'D BY REGISTRAR DATE: MAR 11 1969	25b. REGISTRAR'S SIGNATURE: Helen Yonge	

VR A15 (4)
30M REV. 1/68

ALBERT	LEE	DAYTON	DONNA	JEAN	SELF		
CUMBERLAND	SACRED HEART HOSPITAL		NONE		NONE		
CUMBERLAND,	USA		X	ALLEGANY			
FEMALE	WHITE	2-21-69					

02-21 69 02-21 69 02-21 69

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01778 01770

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Margaret	Loretta	Dick	at 4:40 P.M. February 4, 1969	P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	1/13/1878	91 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U. S. A.	WIDOWED [X]	Allegany County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Allegany County Infirmary	Housewife	Own home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	15 S. Allegany Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles		Morgan	Bridget		Moran

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No.	214-07-5002-D	P. O. Box 599, Allegany County Infirmary records.	Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs / yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 1/25, 1969, to 2/4, 1969, that (I) (we) last saw the deceased alive on 2/3, 1969, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did) (did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
George M. Simons	M.D	[X]	[ ]	[ ]	2/4/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
George M. Simons	Memorial Hospital Cumb. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/7/69	St. Peter's Cemetery	Westernport, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Md.	FEB 10 1969	Richard Lange

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M1
30M REV. 1-68

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01779 Item15 Film6410 3/14/69 kk

CERTIFICATE OF DEATH

01771

1. DECEASED-NAME (Type or print)	First: Charles	Middle: Lewis	Last: Eirich	2a. DATE OF DEATH @ 12:25 P.M. Month: February Day: 24, Year: 1969	2b. HOUR P.M. M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 5/21/1886	6. AGE (In years last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: Allegany USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany County Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired: Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Factory Macaroni		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 759 Maryland Avenue	
14. FATHER'S NAME First: Martin	Middle: Joseph	Last: Eirich	15. MOTHER'S MAIDEN NAME First: Mary Emma Sophia	Middle: Jane	Last: Drainer Crutchley
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-05-9294	17. INFORMANT: P.O.Box 599, Address: Cumberland, Md. Allegany County Infirmary records.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days.

185 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Acute renal insufficiency — 2 days.

DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma of Prostate not Known

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Feb. 7, 19 69, to Feb. 24, 19 69, that (I) (we) last saw the deceased alive on Feb. 24, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John A Tapper	MD	☒	☒	☒	2-25-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A Tapper MD	Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 27, 1969	Rose Hill Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	FEB 28 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
30M REV. (1-68)

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01780

01772

1. DECEASED-NAME (Type or print)	First: GERTRUDE	Middle: E.	Last: EMERICK	2a. DATE OF DEATH: FEBRUARY 24, 1969	2b. HOUR: 4:10 PM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 6-25-1889	6. AGE (In years last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH: ALLEGANY		Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNA.	13b. COUNTY: BEDFORD	13c. CITY OR TOWN: HYNDMAN	13d. INSIDE CITY LIMITS? YES X / NO	13e. STREET AND NUMBER: RT. 1	
14. FATHER'S NAME First: NORMAN	Middle	Last: LEPLEY	15. MOTHER'S MAIDEN NAME First: MARTHA	Middle: BOYER	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service): 217-07-6732	17. INFORMANT (Address): MEMORIAL HOSPITAL, CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF

(b): Carcinoma Ovary

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1830

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Dec, 1968, to Feb 24, 1969, that (I) (we) last saw the deceased alive on Feb 24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
William P James			☑	☐	2/25/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. WILLIAM P. IAMES	441 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 27, 1969	Comps Cemetery	Hyndman, Pa. Somerset, Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler,	Hyndman, Pa.	MAR 3 1969	County Judge. RD#1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01781 — 01773

1. DECEASED-NAME (Type or print): First JAMES; Middle FERMAN; Last HAGER
2a. DATE OF DEATH: FEBRUARY 21, 1969
2b. HOUR: 5:30 PM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 12-16-1893
6. AGE (In years last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED Millwright
12b. KIND OF BUSINESS OR INDUSTRY: Fibres, Celanese
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: RT. 2 WILLIAMS RD.
14. FATHER'S NAME: First WILLIAM; Middle C.; Last HAGER
15. MOTHER'S MAIDEN NAME: First EDNA; Middle M.; Last ARDINGER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No, (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 214-07-6114
17. INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Celus
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetic Mellitus

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 2-21, 1969, to 2-21, 1969, that (I) (we) last saw the deceased alive on 2-21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: William P James — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 2/22/69
22d. PHYSICIAN'S NAME (Type): DR. W. P. JAMES
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/24/69
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery,
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.
24. FUNERAL DIRECTOR: H. Wayne George — ADDRESS: Cumberland, Maryland
25a. REGISTRAR — DATE: FEB 25 1969
25b. REGISTRAR'S SIGNATURE: for Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 3M
45M - IX-68

01782

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01774

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: GEORGE	Middle: S.	Last: HANSROTE	2a. DATE OF DEATH Month: 2 Day: 14 Year: 69	2b. HOUR OF DEATH: 9:30 A.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 12-25-09	6. AGE (In years last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY		Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Engineer	12b. KIND OF BUSINESS OR INDUSTRY: B&ORR		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: ELLERSLIE	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: BOX 35	
14. FATHER'S NAME First: GEORGE	Middle: F.	Last: HANSROTE	15. MOTHER'S MAIDEN NAME First: MALINDA	Middle:	Last: LEASURE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-07-6270	17. INFORMANT: MEMORIAL HOSPITAL -	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos

DUE TO, OR AS A CONSEQUENCE OF

(b): Bronchogenic Carcinoma — 6 mos

DUE TO, OR AS A CONSEQUENCE OF

(c):

1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from Sept, 1968, to 2-14, 1969, that (I) (we) last saw the deceased alive on 2-14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: William P. James DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 2/17/69

22d. PHYSICIAN'S NAME (Type): DR. WILLIAM P. IAMES — 22e. ADDRESS: 441 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2-17-69	23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Memorial Gns.	23d. LOCATION (City or Town): La Vale	(County): Allegany (State): Md.
24. FUNERAL DIRECTOR: Harvey H. Zeigler	ADDRESS: Hyndman, Pa.	25a. REC'D BY REGISTRAR DATE: FEB 20 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

VR A15 (Rev. 45M - 1/68)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
45M - 1X

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01783 — 01775

1. DECEASED-NAME (Type or print) First: LESLIE	Middle: B.	Last: HARTSOCK	2a. DATE OF DEATH: FEBRUARY Month 18 Day 1969 Yr.	2b. HOUR: 4:15 A.M.
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-11-1893	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH: ALLEGANY Md.	
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MACHINIST HELPER	12b. KIND OF BUSINESS OR INDUSTRY: RAILROAD	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES / NO X	13e. STREET AND NUMBER: RT.#2 DE HAVEN ROAD
14. FATHER'S NAME First: ENSLEY	Middle	Last: HARTSOCK	15. MOTHER'S MAIDEN NAME First: CLARA	Middle	Last: WILLISON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-10-1684	17. INFORMANT Address: MEMORIALHOSPITAL, CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation Pulmonary Edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis — years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospitol) attended the deceased from Jan 7, 1969, to Feb 18, 1969, that (I) (we) last saw the deceased alive on Feb 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 2/18/69

22d. PHYSICIAN'S NAME (Type): BLANE M. SCHINDLER, M.D. — 22e. ADDRESS: 43 GREEN ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: FEB. 21, 1969	23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY	23d. LOCATION (City or Town): CUMBERLAND,	(County): MD.	(State): Md.
24. FUNERAL DIRECTOR: BYRON KIGHT	ADDRESS: CUMBERLAND, MD.	25a. RECD BY REGISTRAR DATE: FEB 24 1969	25b. REGISTRAR'S SIGNATURE: [signature]		

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01784

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01776

1. DECEASED-NAME (Type or Print) First: MARY	Middle:	Last: HARTSOCK	2a. DATE KNOWN OF DEATH ESTIMATED: Month Day Year: FEB. 9, 1969			2b. HOUR: 12:20p M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: OCT. 26, 1892	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month Day Year: FEBRUARY 9, 1969	2d. HOUR: 12:20p M
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL-DOA	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED EMPLOYEE OF FOOTER CLEANERS	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES X NO ☐	13e. STREET AND NUMBER: 510 BEALL STREET			
14. FATHER'S NAME First: Edward	Middle: **********	Last: Drake	15. MOTHER'S MAIDEN NAME First: Catherine	Middle:	Last: Imes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-05-7035	17. INFORMANT: Mrs. Earl Judy	ADDRESS: 510 Beall Street Cumberland, Md				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ATELECTASIS, BILATERAL; PULMONARY EMBOLISM — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): VENTRICULAR FIBRILLATION

DUE TO, OR AS A CONSEQUENCE OF

(c): CORONARY SCLEROSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES X NO ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED: FEBRUARY 9, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/12/69	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service	ADDRESS: 21502 Cumberland, Md	25a. REC'D BY REGISTRAR DATE: FEB 14 1969	25b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01785 01777

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	DOROTHY	ANGELA	HENDRICKS	2a. DATE OF DEATH Month / Day / Year	2 / 25 / 1969
2b. HOUR	8 P M				
3. SEX	FEMALE				
4. RACE	WHITE				
5. DATE OF BIRTH	JUNE 28, 1901				
6. AGE (In years last birthday)	67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country)	MARYLAND				
7b. CITIZEN OF WHAT COUNTRY?	USA				
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐					
9. COUNTY OF DEATH	ALLEGANY Md.				
10. CITY OR TOWN OF DEATH	CUMBERLAND				
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	CUMBERLAND CONV. CENTER				
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	RET. SCHOOLTEACHER				
12b. KIND OF BUSINESS OR INDUSTRY	SCHOOLS				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MARYLAND				
13b. COUNTY	ALLEGANY				
13c. CITY OR TOWN	CUMBERLAND				
13d. INSIDE CITY LIMITS? YES ☐ NO ☒					
13e. STREET AND NUMBER	BOX 88, ROUTE 3,				
14. FATHER'S NAME First / Middle / Last	PETER T. FOOTEN				
15. MOTHER'S MAIDEN NAME First / Middle / Last	JULIA	KELLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	NO				
16b. SOCIAL SECURITY NO.	234 62 2659				
17. INFORMANT Address	JULIA SIEHLER, RT. 3, Cumberland, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia (Viral) — years
DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from July, 1968, to Feb 25 1969, that (I) (we) last saw the deceased alive on Feb. 22 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED	2/27/69
22d. PHYSICIAN'S NAME (Type)	BLANE M. SCHINDLER, M.D.	22e. ADDRESS	43 GREENE ST. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	FEB. 28, 1969	HILLCREST BURIAL PARK	CUMBERLAND, MD.	
24. FUNERAL DIRECTOR	BYRON KIGHT	ADDRESS	CUMBERLAND, MD.	
25a. REC'D BY REGISTRAR DATE	MAR 3 1969	25b. REGISTRAR'S SIGNATURE		

VR A15 (2) 30M REV. 68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01786 — 01778

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARY	Middle: E.	Last: HOBELL	2a. DATE OF DEATH Month: FEBRUARY Day: 5, Year: 1969	2b. HOUR: 3:40 PM	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 4-15-1912	6. AGE (In years last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: LAVALE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 12½ PARKSIDE BOULEVARD		
14. FATHER'S NAME First: JACOB	Middle: E.	Last: KELLER	15. MOTHER'S MAIDEN NAME First: MARIE	Middle: E.	Last: TROUT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis c ascites — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO, OR AS A CONSEQUENCE OF (b): Ovarian Ca — 1½ to 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1830

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Ascites, edema, hypoproteinemia due to (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
one yr ago	Abd mass	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) (this hospital) ottended the deceased from JAN. 31, 19 69, to FEB. 5, 19 69, thot (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (aur) opinian deoth accurred on the dote ond hour and from the causes stated above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
A. J. Mirkin M.D.		☒	☐	☐	2/8/1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A.J.MIRKIN	115 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/8/1969	Sunset Memorial Park	Near Cumberland Alleg Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Hafer	Charles E. Hafer, 230 Balto Ave. Cumberland Md	FEB 10 1969	

VR A15 (M) 45M - 1/69

Item 13 See birth cert.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01787 — 01779

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MELISSA	SUE	HOOVER	FEBRUARY 4, 1969	2:30 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	FEBRUARY 3, 1969	— YRS.		17 / 19

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
CUMB., MD.	U.S.A.	NEVER MARRIED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	MEMORIAL HOSPITAL	None	None

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
~~W.Va Md 1 day~~	~~Morgan~~ Allegany	~~Paw Paw~~ Cumberland	YES [X] NO [ ]	~~Memorial Hospital~~ Winchester St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
KENNETH		HOOVER	THELMA		CAIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		none	MEMORIAL HOSPITAL,	CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Atelectasis

DUE TO, OR AS A CONSEQUENCE OF (c) Agenesis of Kidneys

7769

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4/3/, 1969, to 4/4/, 1969, that (I) (we) last saw the deceased alive on 4/4/69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R. A. Reiter, M.D.		[ ]	[X]	[ ]	4/4/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. R. A. Reiter, MD	112 Bedford St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 5, 1969	Davis Memorial Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	FEB 7 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-68) 45M - 1-69

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01788

CERTIFICATE OF DEATH

01780

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give neorest town) CORRIGANVILLE
c. LENGTH OF STAY IN 1b 13 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD. b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neares CORRIGANVILLE
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ORPHA Middle B. Last HOUSE

4. DATE OF DEATH Month Feb. Day 14, Year 1969

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH APR. 20, 1900
9. AGE (In years lost birthday) 68 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) PA.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME JOHN FLAMM
14. MOTHER'S MAIDEN NAME CORA B. GRISSINGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-1523B
INFORMANT Evern A. House Address Corrigonville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, metastatic secondary
DUE TO (b) to ovarian carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 1968, to Feb 14, 1969, that I last saw the deceased alive on 1-28, 1969, and that death occurred at 1:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Carlton Brinsfield M.D. ADDRESS (Street, city or town, state) 401 Decatur St Cumberland Md DATE SIGNED

PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD M.D

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb. 16, 1969
22c. NAME OF CEMETERY OR CREMATORY I.O.O.F.
22d. LOCATION (City, town, or county) (State) Berlin, Somerset, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter A. Johnson Berlin, Pa.
24a. REC'D BY REGISTRAR DATE FEB 18 1969
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01789

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01781

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GENEVIEVE	MARY M.	JOLLEY	02 25 69	11:15 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
FEMALE	WHITE	06-17-91	77 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	Housewife,	Own home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES XX NO ☐	739 FAYETTE STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
BENJAMIN	F.	WALTERS	(PIFFER) MARY	ELIZABETH	WALTERS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	None	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Gallbladder — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yes
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1560

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospitol) attended the deceased from 9 Dec., 1968, to 25 Feb., 1969, that (I) (we) last saw the deceased alive on 24 Feb 1969, and that in (my) (our) apinian deoth occurred on the date ond haur and from the couses stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Ernest N. Miltenberger		☒	☐	☐	2/28/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
F. MILTENBERGER, M.D.	122 S. CENTRE ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/28/69	Rose Hill Cemetery	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George GEORGE FUNERAL HOME, 202 GREENE ST., CUMB., MD	MAR 3 1969	

VR A15 (Rev.) 45M - 1-69

FEMALE	WHITE	06-17-01	77
MARYLAND	U.S.A.	XX	ALLEGANY COUNTY,
CUMBERLAND	SACRED HEART HOSPITAL		
MARYLAND	ALLEGANY	CUMBERLAND XX	739 FAYETTE STREET
REMUNIN	, WALTERS	(PIFFER) MARY ELIZABETH	WALTERS
NO	NONE	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502	

3 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01790 — 01782

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
Lavern	Clayton	Leipler	Feb. 2, 1969	1:30 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	5/9/34	34 YRS.			February 2, 1969	3:00 P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
New York	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Near Flintstone	Rural - State Forest	Owner & Operator	Machine Shop

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
New York	Erie	E. Aurora	YES [X] NO [ ]	1303 Center Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Robert	J.	Leipler	Antoinette		Beaser

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	114-26-3887	Md. State Police, Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Shock	Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Ruptured Liver, Multiple Fractures	Sudden
DUE TO, OR AS A CONSEQUENCE OF (c)	(Pilot in Airplane Crash)	

841X

Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	1:30 P.M. Feb. 2 19 69	Pilot--Crashed in small aircraft.

21d. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
	Green Ridge State Forest	Rt. 1.3 Miles North Rt.40.Flintstone,Alleg.Md.

22a. **I certify** that I took charge of the remoins described above, held on Autopsy [X], Inspection [X] Inquiry [X], and in my opinian death resulted from: Notural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED February 2, 1969

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/5/69	Oakwood Cemetery	E.Aurora, Erie, New York

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Hafer, 230 Balto. Ave., Cumberland, Md.	FEB 4 1969	J. Charles Jusga

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01791

01783

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A10-(4)
30M REV. (1-68)

1. DECEASED-NAME (Type or print)	First: HELENA	Middle: L.	Last: LOAR	2a. DATE OF DEATH: Month FEB. Day 21 Year 1969	2b. HOUR: 6:00 A.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: JULY 29, 1902	6. AGE (In years last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MINERS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: ROUTE 1	
14. FATHER'S NAME First: ERNEST	Middle	Last: WINDERKNECHT	15. MOTHER'S MAIDEN NAME First: LOUISA	Middle	Last: RUETGER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-48-3120	17. INFORMANT Address: GEO. F. LOAR, BOX 476, RT. 1, FROSTBURG, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b): HCVRD. — Years
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 2/20/69, 19—, to 2/21/69, 19—, that ~~(I saw)~~ last saw the deceased alive on ____ 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John B. Davis		[X]	[ ]	[ ]	2/21/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN B. DAVIS, M. D.	BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	FEB. 23, 1969	SUNSET MEMORIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	FEB 24 1969	[illegible] Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01792 — 01784

1. DECEASED-NAME (Type or Print)	First: Harry	Middle: Wilbur	Last: Long
2a. DATE KNOWN OF DEATH ESTIMATED	Month Doy Year: Feb. 14, 1969	2b. HOUR: 4:40p M	
3. SEX: Male	4. RACE: Cau.	5. DATE OF BIRTH: 2/2/14	6. AGE (In years last birthday): 55 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
2c. DATE PRONOUNCED DEAD	Month Day Year 19: February 14, 1969	2d. HOUR: 4:40p M	
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Memorial Hosp. (D.O.A.)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY: S. Co. Constr. Bldg.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Mt. Savage	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER: Railroad St.
14. FATHER'S NAME	First: Orion	Middle: Robert	Last: Long
15. MOTHER'S MAIDEN NAME	First: Claudia	Middle:	Last: McCormick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes W.W. # II	16b. SOCIAL SECURITY NO.: 214-05-7851	17. INFORMANT: Mrs. Iona A. Long	ADDRESS: Railroad St. Mt. SAvage, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY THROMBOSIS, LEFT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described abave, held an Autapsy [X], Inspectian [X], Inquiry [X], and in my apinian death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: February 14, 1969

ADDRESS(Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/17/69	23c. NAME OF CEMETERY OR CREMATORY: St. George Episcopal Cem.	23d. LOCATION (City or Town) (County) (State): Mt. Savage, Allegany, Md.	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: FEB 18 1969	25b. REGISTRAR'S SIGNATURE: Wilma Unger	

VR A15ME (5) 10M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01793 01785

1. DECEASED-NAME (Type or print): First ~~LUZIER~~ THEODORE Middle ~~CYRUS~~ Lost LUZIER — First ~~THEODORE~~ Middle CYRUS Lost LUZIER

2a. DATE OF DEATH: Month 2 Day 26 Year 69

2b. HOUR: 4:25 PM

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: 12/16/01

6. AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS 2 DAYS 10 IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (State or foreign country): W. VA.

7b. CITIZEN OF WHAT COUNTRY? UNITED STATES

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: ALLEGANY Md.

10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LUMBER INSPECTOR

12b. KIND OF BUSINESS OR INDUSTRY: LUMBER

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VA.

13b. COUNTY: MINERAL

13c. CITY OR TOWN: MT. STORM

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET AND NUMBER:

14. FATHER'S NAME First JAMES Middle Ellsworth Lost LUZIER

15. MOTHER'S MAIDEN NAME First (AUVIL) EMMA Middle Lost LUZIER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16b. SOCIAL SECURITY NO. 236 16 9210

17. INFORMANT: PATIENT'S HOSP. CHART Address: 900 SETON DRIVE CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) HEART BLOCK, COMPLETE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

DIABETES MELLITUS UREMIA, ELECTROLYTE ABNORMALITIES

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 2-21-69, 19____, to 2-26-, 19 69, that (I) (we) last saw the deceased alive on 2-26- 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dr. Matthew L Kauf DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 2-26-69

22d. PHYSICIAN'S NAME (Type): DR. MATTHEW L. KAUFFMAN

22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-1-69

23c. NAME OF CEMETERY OR CREMATORY: Bayard Cemetery

23d. LOCATION (City or Town) (County) (State): Bayard, W.Va.

24. FUNERAL DIRECTOR: MARKWOOD FUNERAL HOME, KEYSER, W. VA. ADDRESS: Harold W. McKenzie 26726

25a. REC'D BY REGISTRAR DATE: MAR 4 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01794 01786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: BASIL	Middle: Thomas	Last: MARKS	2a. DATE OF DEATH Month: 2 Day: 22 Year: 69	2b. HOUR: 9:07 A M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 5-12-06	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): PA.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY CO. Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RT. 4	
14. FATHER'S NAME First: WILLIAM	Middle	Last: MARKS	15. MOTHER'S MAIDEN NAME First: ~~XXXX~~ Alta	Middle: ABA	Last: HEASTLEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-05-9252	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	7 wks
DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinoma Stomach	4 mos
DUE TO, OR AS A CONSEQUENCE OF (c)	Myocarditis & Decompensation	3 wks

151.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from Feb. 10, 19 69 to Feb. 22, 19 69, that (I) (we) last saw the deceased alive on Feb. 22 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Clark Durrett	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 2/23/69
22d. PHYSICIAN'S NAME (Type): DR. C. DURRETT	22e. ADDRESS: CUMBERLAND, MD.				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/25/1969	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State): Near Cumberland, Alleg Md	
24. FUNERAL DIRECTOR: Charles E. Hafer, 230 Balto Ave. Cumberland Md.	ADDRESS	25a. RECD BY REGISTRAR DATE: FEB 26 1969	25b. REGISTRAR'S SIGNATURE: Clarence Snider	

VR A15 (01)
45M - 1X68

#0 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01795 01787

1. DECEASED-NAME (Type or print): First JOHN Middle Arthur Last MC DADE
2a. DATE OF DEATH: 2 Month 2 Day 69 Year
2b. HOUR: 9:00 AM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 8-8-22
6. AGE (In years last birthday): 46 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: US OF A
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life. (Even if retired.)): CLERK
12b. KIND OF BUSINESS OR INDUSTRY: TIMES NEWS
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 520 FAYETTE STREET
14. FATHER'S NAME: First JAMES Middle Leo Last MC DADE
15. MOTHER'S MAIDEN NAME: First (MICHAELS) SARA Middle H Last MC DADE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES (If yes give war or dates of service): WWII
16b. SOCIAL SECURITY NO.: 217-14-4153
17. INFORMANT: HOSPITAL RECORDS Address: 900 SETON DR. CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 hrs
485X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Adenocystical Carcinoma c Extensive Liver Metastases

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [✓]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 2/1, 1969, to 2/2, 1969, that (I) (~~we~~) last saw the deceased alive on 2/1 1969, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. A. Pagan
DEGREE: ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 2/3/69
22d. PHYSICIAN'S NAME (Type): J. A. PAGAN, M.D.
22e. ADDRESS: 1068 NATIONAL HWY, LA VALE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/5/69
23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cem.
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md.
24. FUNERAL DIRECTOR: James Stein Inc. ADDRESS: STEIN'S FUNERAL HOME, 117 FREDERICK, CUMBERLAND, MD.
25a. RECD BY REGISTRAR DATE: FEB 5 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

01796

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01788

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
FLORENCE	M.	MC ELFISH	2	21	69	7:10 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	7 22 95	73 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	LA VALE	YES ☒ NO ☐	1105 BRADDOCK ROAD

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HARVEY		MILLER	NETTIE	LANGLEY	MILLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	225 64 4477	SACRED HEART HOSPITAL	900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Embolism

DUE TO, OR AS A CONSEQUENCE OF (b) Atrial fibrillation

DUE TO, OR AS A CONSEQUENCE OF (c) Arteria - sclerosis Cardio - Vascular

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Congestive Heart failure.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Clarence J. Vincent - M.D.		☒	☐	☐	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. CLARENCE VINCENT	912 SETON DRIVE -CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2/24/1969	Rose Hill Cemetery	Cumberland,	Alleg	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HAFER'S FUNERAL HOME	LAVALE, MARYLAND	FEB 26 1969	

VR A15 - 45M - 1969

FLORENCE M. MC ELFISH 2 21 69 7:10

FEMALE WHITE 7 22 95 73

MARYLAND USA X ALLEGANY

CUMBERLAND SACRED HEART HOSPITAL HOUSEWIFE

MARYLAND ALLEGANY LA VALE X 1165 BROADOCK ROAD

HARVEY MILLER NETTIE LANGLEY MILLER

NO 2259 64 4477 SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND, MD.

DR. CLARENCE VINCENT 912 SETON DRIVE -CUMBERLAND, MARYLAND

HAFER'S FUNERAL HOME -LAVALE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01797 — 01789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: John	Middle: Richard	Last: McPartland	2a. DATE OF DEATH: Month Feb. Day 2 Year 1969	2b. HOUR: 6A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Aug. 3, 1904	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.		
10. CITY OR TOWN OF DEATH: Barton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Salesman	12b. KIND OF BUSINESS OR INDUSTRY: Gas. Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Barton	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: Legislature Road	
14. FATHER'S NAME First: Patrick	Middle: A	Last: McPartland	15. MOTHER'S MAIDEN NAME First: Marry	Middle:	Last: Higgins
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 200-07-4489	17. INFORMANT: Address: Barton, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Ischemia

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized Arteriosclerosis

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Influenza — Degenerative Arthritis Psoriasis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 1958 to Feb. 2 1969, that (I) (we) last saw the deceased alive on Jan. 28 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Leslie R. Miles M.D.	DIVORCE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 2-3-69
22d. PHYSICIAN'S NAME (Type): Leslie R. Miles	22e. ADDRESS: Lonaconing, Md.				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/5/69	23c. NAME OF CEMETERY OR CREMATORY: St. Gabriels	23d. LOCATION (City or Town): Barton	(County) (State): Md.
24. FUNERAL DIRECTOR: [illegible] Brad	ADDRESS: Westernport, Md.	25a. REC'D BY REGISTRAR DATE FEB 5 1969	25b. REGISTRAR'S SIGNATURE: [illegible] Charles Judge	

VR A15(N) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01798 — 01790

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Fannie	Mae	Meade	Feb. 21, 69	4:45 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female,	White	April 14, 1888	80 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Penna.	U. S. A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland,	306 Mountain View Drive	Housewife,	Own home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland,	YES ☒ NO ☐	306 Mountain View Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	--	Kime	Wilhelmina	--	Dengler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No,	None	Mr. Edward W. Meade 20 Radnor Dr. Melbourne, Fla.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis — 1/2 hrs

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension C & Arsen, — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4120

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 1, 1966, to Feb 21, 1969, that (I) (we) last saw the deceased alive on May 31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]		☒	☐	☐	2/24/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Blane M. Schindler, M. D.	43 Greene St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/25/69	Lutheran Cemetery,	Lewistown, Mifflin, Penna.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George 202 Greene St. Cumberland, Md.	FEB 26 1969	Charles Judge

1

FOR STATE HEALTH DEPT.

01799

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01791

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First	Middle	Last
	William	Arnold	Moreland

2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month Day Year: Feb. 17, 1969 — 2b. HOUR: 1:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN.
Male	White	July 3, 1947	21 YRS.				

2c. DATE PRONOUNCED DEAD Month Day Year 19: February 17, 1969 — 2d. HOUR: 2:30 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
W.Va.	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
rural-Westernport	100 Elain St. Westernport, Md	Laborer	Coal Mine

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Westernport	YES [ ] NO [X]	100 Elain St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	W.	Moreland	Dorothy	A.	Wolfe

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		219-52-2304	Dorothy A. White	Westernport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crushed Skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
916 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) (Crushed by transmission of auto)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
	1:30 P.M. Feb. 17 1969	Transmission of auto fell on head

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	100 Elain St.	Westernport,	Maryland,	Allegany,	Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: February 17, 1969
ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/20/69	Bloomington	Bloomington Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. J. Boal	Westernport, Md.	FEB 20 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01800 01792

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARY	V.	MORGAN	02 05 69	12:05 A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	07-19-24	44 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of wark done during mast af warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES [X] NO [ ]	57 BROADWAY

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
FRANK		SHRIVER	(BLANK) MARGARET		SHRIVER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	NONE	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma of cervix c	1 1/2 yrs
DUE TO, OR AS A CONSEQUENCE OF (b)	local and distant metastases	
DUE TO, OR AS A CONSEQUENCE OF (c)		

180X
Conditians, if ony, which gave rise to immediate cause (a), stoting the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. No.	City ar Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from Feb. , 1965, to Feb 4 , 1969, that (I) (we) last saw the deceased alive an Feb 4 1969, and thot in (my) (our) opinion death accurred an the date ond hour and from the causes stoted abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Thomas F. Lewis	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	2/5/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
T. LEWIS, M.D.	500 GREENE ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2/7/69	FROSTBURG MEM. PARK	FROSTBURG, ALLEGANY, MD.

24. FUNERAL DIRECTOR	ADDRESS	25. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
MARILOU M. SOWERS HAFER-SOWERS	FROST., MD. 21532 FUNERAL HOME, 60 W. MAIN ST.,	FEB 11 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-68

MARY V. MORGAN 02 05 69 12:05

FEMALE WHITE 07-13-24 LL

M PYLAND U.S.A. ALLEGHNY COUNTY,

CUMBERLAND SACRED HEART HOSPITAL

MARYLAND ALLEGHNY FROSTBURG X 57 ARMORY

FRANK SHEETZ (BLANK) MARGARET SHEETZ

NO SACRED HEART HOSPITAL, 300 SEVEN PA., NURS..

T. LEWIS, M.D. 500 GREENE ST., CUMB., MD. 21502

SENTAL 2/7/69 FROSTBURG MEM., FAMILY FROSTBURG, ALLEGHANY, MD.

FIRST., MD. 21532

HAFEI -SOMERS FUNERAL HOME, 60 W. MAIN ST..

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01801 — 01793

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 10M REV. 1-68

1. DECEASED-NAME (Type or print) First	James	Middle: Gibbons	Last: Naughton
2a. DATE OF DEATH Month Day Year	February 7, 1969 at 9:50 P.M.	2b. HOUR	P.M. M
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	10/27/1888		
6. AGE (In years last birthday)	80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	Maryland		
7b. CITIZEN OF WHAT COUNTRY?	U. S. A.		
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	Allegany County Md.		
10. CITY OR TOWN OF DEATH	Cumberland		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Allegany County Infirmary		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Retired Telegraph Op.	12b. KIND OF BUSINESS OR INDUSTRY	C&P R.R.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.	13b. COUNTY	Allegany
13c. CITY OR TOWN	Westernport	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 95 Main Street
14. FATHER'S NAME First	Michael	Middle	Lost: Naughton
15. MOTHER'S MAIDEN NAME First	Ann	Middle	Lost: Daily
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO.	712-14-1575		
17. INFORMANT Address	P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarction — Few minutes

DUE TO, OR AS A CONSEQUENCE OF (b) Chr. ASHD — many years

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — many years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from Dec. 18, 1967, to Feb. 7, 1969, that (I) (we) last saw the deceased alive an Feb. 7, 1969, and that in (my) (aur) opinion death accurred on the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	John A. Topper	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 2-10-69
22d. PHYSICIAN'S NAME (Type)	John A. Topper MD	22e. ADDRESS	Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE: 2/10/69	23c. NAME OF CEMETERY OR CREMATORY: Philos	23d. LOCATION (City or Town) (County) (State): Westernport Md.
24. FUNERAL DIRECTOR	E. L. Boal	Westernport, Md.	25a. REC'D BY REGISTRAR DATE: FEB 14 1969	25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01802 — 01794

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WILLIAM	O	PAXTON	2 3 69	11:40 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	7-15-13	55 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND,	MEMORIAL HOSPITAL	STATION OPERATOR	GASOLINE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND		996 MC MULLEN HIGHWAY

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
MC CLURE		PAXTON	HELEN		FRANTZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	214-05-4657	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 571.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from June, 1958, to Feb 3, 1969, that (I) (we) last saw the deceased alive on Feb 3 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED
William P. James					2/8/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. P. JAMES	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2/6/69	Sunset Memorial Park	Cumberland, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Byron Kight	Cumberland, Md.	FEB 11 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (2)
45M - 1/69

01803

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01795

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: DENNIS	Middle: I	Last: POWELL	2a. DATE OF DEATH Month Day Year	FEBRUARY 1, 1969	2b. HOUR AM/PM: 10:25 PM
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH	11-15-1868	6. AGE (In years last birthday) 100 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN				
7a. BIRTHPLACE (State or foreign country)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH	CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MD	13b. COUNTY	ALLEGANY	13c. CITY OR TOWN	CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER	708 LAFAYETTE AVE.,					
14. FATHER'S NAME First	ALBERT	Middle		Last	POWELL	
15. MOTHER'S MAIDEN NAME First	LAVINA	Middle		Last	SHAFFER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	Unknown	17. INFORMANT Address	MEMORIAL HOSPITAL, CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial atelectasis Hurt Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: gone
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** thot (I) (this hospitol) ottended the deceased from Jan 65, to Feb 1, 69, that (I) (we) lost sow the deceased alive on Feb 1 19 69 ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Blane Schindler — DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐ — 22c. DATE SIGNED: 2/2/69

22d. PHYSICIAN'S NAME (Type): DR. BLANE SCHINDLER — 22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/5/69	Mt Olivet Cemetery	Frederick Frederick Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service	Cumberland, Md 21502	FEB 5 1969	[illegible] Yeager

VR A15 (3) 45M - 1/68

DENNIS I POWELL FEBRUARY 1, 1969

MALE WHITE 11-15-1868 100

MARYLAND USA X ALLEGANY

CUMBERLAND, MD. MEMORIAL HOSPITAL

MD ALLEGANY CUMBERLAND X 708 LAFAYETTE AVE.,

ALBERT POWELL LAVINA SHAFFER

NO Unknown MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. BLANE SCHINDLER 43 GREENE ST., CUMBERLAND, MD.

Buried 2/4/69 Mt Olivet Cemetery Frederick, Frederick Maryland

Hilleary-Merritt Funeral Services Cumberland, Md

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01804 — 01796

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED-NAME (Type or print) First	Walter	Middle B.	Lost Powell
2o. DATE OF DEATH Month Doy Year	Feb. 9 69	2b. HOUR	10:15 A M
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	July 7, 1919		
6. AGE (In years last birthday)	49 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7o. BIRTHPLACE (State or foreign country)	Levels, W.Va.	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	Allegany Md.
10. CITY OR TOWN OF DEATH	Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	D.O.A. Memorial Hospital
12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY	Cement Co.
13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	W. Va.	13b. COUNTY	Mineral
13c. CITY OR TOWN	Ridgeley	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET AND NUMBER	Route 1		
14. FATHER'S NAME First	Floyd	Middle	Lost Powell
15. MOTHER'S MAIDEN NAME First	Mary	Middle Moreland	Lost
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	no	(If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT Address	Mrs. Helen Powell, Ridgeley, W.Va.-Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) Sudden Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 Feb. 69
DUE TO, OR AS A CONSEQUENCE OF (b) A. S. Hert disease with myocardial infarction — 2/8 p.m. 67 Inferm
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic valvular Heart disease, mitral insuff. ? probably rheumatic
Conditions, if any, which gave rise to immediate couse (o), stoting the underlying couse lost.
4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While [ ] ot work Not while [ ] ot work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote

22o. **I certify** thot (I) (this hospitol) ottended the deceosed from 21 January, 1967, to 9 February 1969, thot (I) (we) lost sow the deceosed olive on 4 February 1969, ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted obove, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	W. A. Van Ormer, M.D.	DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED 10 February 1969
22d. PHYSICIAN'S NAME (Type)	Dr. W. A. Van Ormer, MD.	22e. ADDRESS	122 S. Centre St., Cumberland, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
Burial	Feb. 12, 1969	Fort Ashby Cemetery	Fort Ashby, W.Va.	
24. FUNERAL DIRECTOR	James F. Scarpelli, Cumberland, Md.	ADDRESS	25o. REC'D BY REGISTRAR DATE FEB 11 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01805

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01797

1. DECEASED-NAME (Type or Print)	First: Mary	Middle: Emma	Last: Rhodes	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: Feb. 15, 1969	2b. HOUR: 3p M						
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: June 25, 1868	6. AGE (In years last birthday): 100 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month Day Year: February 15, 1969	2d. HOUR: 3:30 P M				
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.								
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 314 Frederick Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 314 Frederick Street							
14. FATHER'S NAME First: Joseph	Middle	Last: Davis	15. MOTHER'S MAIDEN NAME First: Eliza	Middle	Last: Davis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 377-54-6147	17. INFORMANT ADDRESS: John H. Rhodes, 319 Frederick St., Cumberland, Md.								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

I 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]	
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Manth, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22a. **I certify** that I took charge of the remains described abave, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: February 15, 1969

ADDRESS(Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/18/69	23c. NAME OF CEMETERY OR CREMATORY: Sumner Cemetery	23d. LOCATION (City or Town) (County) (Stote): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: John J. Hafer, Jr.	ADDRESS: John J. Hafer, Jr., 230 Balto. Ave., Cumberland, Md.	25a. REC'D BY REGISTRAR: FEB 19 1969	25b. REGISTRAR'S SIGNATURE	

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01806 01798

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 7-68

1. DECEASED-NAME (Type or print)	First: JOSEPHINE	Middle: L.	Last: RICE	2a. DATE OF DEATH	Month: 2	Day: 3	Year: 69	2b. HOUR: 3:35 PM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 07-02-[redacted]88	6. AGE (In years last birthday): [redacted]80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.			
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.					
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY: NONE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 7 MARKET STREET				
14. FATHER'S NAME: First: JOSEPH	Middle:	Last: LINDNER	15. MOTHER'S MAIDEN NAME: First: MARY	Middle:	Last: READY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 714-16-2733	17. INFORMANT: HOSP. REC.	Address: 900 SETON DR., CUMBERLAND, MD.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ABDOMINAL CARCINOMATOSIS	10 MO.
DUE TO, OR AS A CONSEQUENCE OF (b)	ADENOCARCINOMA OF THE DUODENUM	10 MO.
DUE TO, OR AS A CONSEQUENCE OF (c)	UREMIC POISONING	1 MO.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
GENERALIZED VISCERAL FAILURE-GENERALIZED ARTERIOSCLEROSIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NONE		YES ☐ NO ☐ #	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
		NONE	

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	NONE				

22a. **I certify** that (I) (this hospital) attended the deceased from AUG. 27, 19 49, to FEB. 3, 19 69, that (I) (we) last saw the deceased alive on FEB. 3, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. #	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
James P. Hallinan M.D.					FEB. 4, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JAMES P. HALLINAN, M. D. DR. HALLINAN	140 BEDFORD ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/6/69	St. Peter + Paul	Cumberland Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
STINES FUNERAL HOME	Louis Stein Inc Cumb. Md.	DATE: FEB 6 1969	Charles Judge

JOSEPHINE L. RICE 2 3 09 3:35P

FEMALE WHITE 07-02-90 70

MARYLAND USA X ALLEGANY

CUMBERLAND SACRED HEART HOSP. NONE NONE

MARYLAND ALLEGANY CUMBERLAND X 7 MARKET STREET

JOSEPH LINDNER MARY READY

NO 71A-16-2753 HOSP. REC. 900 SETON DR., CUMBERLAND,MD.

ADDOMINAL CARCINOMATOSIS 10 MO.

AGENCY PRIMARY OF THE DUODENUM 10 MO.

UREMIC POISONING 1 MO.

GENERALIZED VISCERAL FAILURE-GENERALIZED ARTERIOSCLEROSIS

NONE

NONE

NONE

FEB. 3, 09 AUG.27, NO FEB.3, 09 --

FEB. 4,1969

JAMES P. HOLLINON, M. D.

DR. HOLLINON 1MO BEDFORD ST., CUMBERLAND, MD.

STINES FUNERAL HOME

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01807 01799

Item6 Film G410 3/10/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ANNA	BELLE	RIGGLEMAN	FEB. 26, 1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	JAN. 21, 1881	88 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	HOUSE WORK	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	MT. SAVAGE	YES ☒ NO ☐	NEW ROW

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HENRY		NORRIS	SARAH		MARTIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
	217-54-6369-JI	MRS. ROSETTA DENNISEAR, MT. SAVAGE, MD .

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) Primary adenocarcinoma, gastric — 6 mos.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Aug. 1968	Gastric resection	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Nov 27, 1968, to Feb 26, 1969, that (I) (we) last saw the deceased alive on Feb 26 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
G Paige Strong	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	2/28/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
G. PAIGE STRONG, M. D.	E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	MAR. 1, 1969	METHODIST CEMETERY	MT. SAVAGE, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, SR., FROSTBURG, MD.	MAR 4 1969	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 12-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01808 01800

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARION	W.	ROBERTSON	FEBRUARY 3, 1969	10:20 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	MAY 4, 1896	72 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U. S. A.	WIDOWED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	HOUSEWIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	WESTERNPORT	YES X NO	148 WOOD ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ROBERT		WILSON	SARAH		WATSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Subarachnoid Hemorrhage	10 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Hypertension	?
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Arteriosclerosis Myocardial Fibrosis	Over 6 years

4121

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Auricular Fibrillation, Generalized Arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO X	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Feb 5, 1963, to Feb. 3, 1969, that (I) (we) last saw the deceased alive on Feb. 3, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Samuel Jacobson		X	☐	☐	2/4/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. SAMUEL M. JACOBSON	50 PERSHING ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	FEB. 7, 1969	PHILOS	WESTERNPORT ALLEG. MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Fredlack Fun. Home	Westernport Md.	FEB 7 1969	Charles Judge

VR A15
45M - 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01809

CERTIFICATE OF DEATH

01801

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Daniel	Howard	Roth	February 18, 1969	6:45 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	October 5, 1882	86 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Kinch Nursing Home	Office Manager	Insurance

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☒ NO ☐	229 Baltimore Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	A.	Roth	Amelia		Stumpner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	215-01-1583	Mrs. Richard Smith, 119 Weber St., Cumberland, M

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
174X	IMMEDIATE CAUSE (a) Anaemia	4 wks
	DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis	2 mos
	DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Left Breast	1 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Nov. 12, 1968, to Feb. 18, 1969, that (I) (we) last saw the deceased alive on Feb. 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Clay E. Durrett		☒	☐	☐	2/19/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Clay E. Durrett, M.D.	Virginia Ave., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Cremation	2/21/69	Loudon Park	Baltimore, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Hafer, 230 Balto. Ave., Cumberland, Md.		FEB 21 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01810 01802

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First Adah; Middle Clara; Last Sapiro

2a. DATE OF DEATH: Month Feb. Day 19 Year 1969

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Dec. 6, 1898

6. AGE (In years last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Allegany Md.

10. CITY OR TOWN OF DEATH: Westernport

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 225 Md. Ave.

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Sales Lady

12b. KIND OF BUSINESS OR INDUSTRY: Appliance

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Allegany

13c. CITY OR TOWN: Westernport

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 225 Md. Ave.

14. FATHER'S NAME: First James; Middle Laffey; Last

15. MOTHER'S MAIDEN NAME: First Bridget; Middle Keedy; Last

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 214-05-7869

17. INFORMANT: Moses Shapiro Address: Westernport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Embolus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 Hours

4109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Multiple Arthritis

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from Mar. 10, 1962, to Feb. 19, 1969, that (I) (we) last saw the deceased alive on Feb 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Paul R Wilson M.D DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: Feb. 20, 1969

22d. PHYSICIAN'S NAME (Type): Paul R. Wilson

22e. ADDRESS: Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: Feb. 22, 69

23c. NAME OF CEMETERY OR CREMATORY: St. Peters

23d. LOCATION (City or Town) (County) (State): Westernport Md.

24. FUNERAL DIRECTOR: E. L. Boal ADDRESS: Westernport, Md.

25a. REC'D BY REGISTRAR DATE: FEB 24 1969

25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (M) 30M REV. 11-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01811 — 01803

1. DECEASED-NAME (Type or print)	First: FRANK	Middle: HENRY	Last: SHROUT	2a. DATE OF DEATH Month Day Year: FEBRUARY 9, 1969	2b. HOUR: A 12:50 M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: MARCH 4, 1880	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): NEW YORK	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RAILROAD	12b. KIND OF BUSINESS OR INDUSTRY: RAILROAD		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: Alleg.	13c. CITY OR TOWN: ELLERSLIE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: BOX 93	
14. FATHER'S NAME First / Middle / Last: TAYLOR / / SHROUT	15. MOTHER'S MAIDEN NAME First / Middle / Last: (JONES) / EMMA / SHROUT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 235-72-1480	17. INFORMANT Address: HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Ventricular arrhythmia Hypokalemia	4123
DUE TO, OR AS A CONSEQUENCE OF (b)	Carotid Insufficiency	yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Bronchogenic Ca of Lung	yrs / 1 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to July 9, 1969, that (I) (we) last saw the deceased alive on July 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/9/69	
22d. PHYSICIAN'S NAME (Type): BLANE M. SCHINDLER, M.D.	22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD. 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: FEB. 12 1969	23c. NAME OF CEMETERY OR CREMATORY: LAHMANSVILLE CEMETERY	23d. LOCATION (City or Town) (County) (State): LAHMANSVILLE GRANT WEST VIRG.	
24. FUNERAL DIRECTOR ADDRESS: H. LEE SILCOX 404 DECATUR ST., CUMBERLAND MD.	25a. REC'D BY REGISTRAR DATE: FEB 11 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge		

VR A15 (4) 45M - 1/69

1

01812

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item13 FilmG410 3/4/69 kk

01804

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	ETHELWYN	Middle M.	Last SIDAWAY	2a. DATE OF DEATH Month FEBRUARY Day 4, Year 1969	2b. HOUR 3:35 P.M.
3. SEX	FEMALE	4. RACE	WHITE	5. DATE OF BIRTH	4-22-08
6. AGE (In years last birthday)	60 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	MARYLAND	7b. CITIZEN OF WHAT COUNTRY?	U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. COUNTY OF DEATH	ALLEGANY Md.				
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY	Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MARYLAND	13b. COUNTY	ALLEGANY	13c. CITY OR TOWN	CUMBERLAND
13d. INSIDE CITY LIMITS?	YES ☒ NO ☐	13e. STREET AND NUMBER	42 HOME Virginia CUMBERLAND NURSING Ave.		
14. FATHER'S NAME First	CHARLES	Middle	Last BOWDEN	15. MOTHER'S MAIDEN NAME First	ELIZABETH
Middle		Last	COOK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-2-69

DUE TO, OR AS A CONSEQUENCE OF (b) Far advanced Arteriosclerosis — Since 1957

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 431.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Uremia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	Caunty / State

22a. I certify thot (I) (this hospitol) ottended the deceased from 4-11-1959, to 2-4-1969, thot (I) ~~(we)~~ lost saw the deceased alive on 2-4-1969 and thot in (my) ~~(our)~~ opinion deoth occurred on the dote and hour and from the couses stoted oboye, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after deoth.

22b. SIGNATURE Wm F. Williams DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 2-5-69

22d. PHYSICIAN'S NAME (Type) DR. W.F.WMS. — 22e. ADDRESS CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	Feb. 7,1969	Davis Memorial Cem.	Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.		FEB 10 1969	Charles Judge	

VR A15 (1)
45M - 1/69

1

01813

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01805

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
45M - 1/69

1. DECEASED-NAME (Type or print)	First: CLARENCE	Middle: M.	Last: SMITH	2a. DATE OF DEATH Month: 2 Day: 16 Year: 69	2b. HOUR: 6:25 P.M.	
3. SEX: MALE	4. RACE: NEGRO	5. DATE OF BIRTH: 12 10 95	6. AGE (In years last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): WEST VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOTEL	12b. KIND OF BUSINESS OR INDUSTRY: HOTEL			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 347 FREDERICK STREET		
14. FATHER'S NAME First: CHARLES	Middle	Last: SMITH	15. MOTHER'S MAIDEN NAME First: MARY	Middle: JOHNSON	Last: SMITH	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 705 10 7963	17. INFORMANT: SACRED HEART HOSPITAL	Address: 900 SETON DRIVE CUMBERLAND, MARYLAND			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): hepatic coma — APPROX. INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO, OR AS A CONSEQUENCE OF (b): Cancer of the pancreas — 1 year

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-6-, 1968, to 2-16, 1969, that (I) (we) last saw the deceased alive on 2/16/69, 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
L Brings	MD		[X]	[ ]	2-17-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. L. BRINGS	57 GREENE ST -CUMBERLAND, MARYLAND 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/19/69	Woodlawn Cem.	Cumberland Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. DEPUTY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lewis Stein Inc.	Cumb. Md.	FEB 21 1969	

CLARENCE M. SMITH 2 16 69 8:25

MALE NEGRO 12 10 05 73

WEST VA. USA

CUMBERLAND SACRED HEART HOSPITAL HOTEL HOTEL

MARYLAND ALLEGANY CUMBERLAND X 247 FREDERICK STREET

CHARLES SMITH MARY JOHNSON SMITH

NO 705 10 7963 SACRED HEART HOSPITAL 200 SETON DRIVE
CUMBERLAND, MARYLAND

DR. L. BRINGS 57 GREENE ST -CUMBERLAND, MARYLAND 21502

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01814 01806

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 Y
45M - 1/69

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
LILLIAN	ANGELA	SMITH	2	5	69	8:03 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
FEMALE	WHITE	2/18/99	69 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
CUMBERLAND, MD.	USA	MARRIED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	SACRED HEART HOSPITAL	HOUSEWIFE	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO	182 N. CENTRE STREET

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
JOHN		DIGGS	CATHERINE	HAMMERSMITH	DIGGS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	705 05 4446	SACRED HEART HOSPITAL	~~900 SETON DRIVE~~ CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mon

DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of ovary — ?

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 1830

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 12-30, 19 68, to 2-5, 19 69, that (I) (we) last saw the deceased alive an 2-5 19 69, and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
WCS Spiggle	ATTENDING PHYS. X / MED. DIRECTOR ☐ / STAFF PHYS. ☐	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. WAYNE SPIGGLE	912 SETON DRIVE -CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 8, 1969	St. Mary's Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Scarpelli Funeral Home	SCARPELLI FUNERAL HOME -108 VA. AVENUE CUMBERLAND, MARYLAND	FEB 10 1969	

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01815 — 01807

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1968

1. DECEASED-NAME (Type or print) First / Middle / Last	Salina / Davis / Smith	2o. DATE OF DEATH Month / Doy / Year	Feb. 10 1969
2b. HOUR	2:30 AM		
3. SEX	Female		
4. RACE	White		
5. DATE OF BIRTH	January 26, 1879		
6. AGE (In years last birthday)	90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7o. BIRTHPLACE (State or foreign country)	Maryland		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	Allegany Md.		
10. CITY OR TOWN OF DEATH	Cumberland		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	Cumb. Nursing Center		
12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife		
12b. KIND OF BUSINESS OR INDUSTRY			
13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland		
13b. COUNTY	Allegany		
13c. CITY OR TOWN	Cumberland		
13d. INSIDE CITY LIMITS?	YES [X] NO [ ]		
13e. STREET AND NUMBER	414 Pulaski St.		
14. FATHER'S NAME First / Middle / Last	Esau / Morgan		
15. MOTHER'S MAIDEN NAME First / Middle / Last	Rebecca / Rinker		
16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	No		
16b. SOCIAL SECURITY NO.			
17. INFORMANT Address	George E. Smith Cumberland, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Arteriosclerotic Cardio vascular disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c) Espasidy cerebrally

Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse last. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21o. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILOING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22o. **I certify** thot (I) (this hospital) attended the deceased from 6-8-67 19___, to 2-11- 19 69, that (I) (~~we~~) lost saw the deceased olive on 1-25 19 69, ond thot in (my) (~~our~~) opinion deoth occurred on the dote ond hour ond from the couses stoted obove, (I) (~~we~~) (~~did~~) (did not) view the body ofter death.

22b. SIGNATURE	Wm. F. Williams M.D.	DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED 2/11/69
22d. PHYSICIAN'S NAME (Type)	Wm. F. Williams, M. D.	22e. ADDRESS	122 S. Centre St., Cumberland, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)	
Burial	2/12/69	Hillcrest Cemetery	Cumberland, Alleg., Md.	
24. FUNERAL DIRECTOR ADDRESS	Philip B. Wendt 121 Memorial Ave., Cumb., Md.	25o. REC'D BY REGISTRAR DATE	FEB 13 1969	25b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

99 01 1

2

2

01816

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01808

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Lost
Nevada	Gay	Stalnaker

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: FEB. 4, 1969 — 2b. HOUR: 5:25p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Female	White	Apr.5,1900	68 YRS.				

2c. DATE PRONOUNCED DEAD Month Day Year: FEBRUARY 4, 1969 — 2d. HOUR: 5:25p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]	9. COUNTY OF DEATH
W.Va.	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	MEMORIAL HOSPITAL-DOA	Waitress	Rest.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	McCoole	YES [ ] NO [X]	Westernport Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Wood		Stalnaker	Sigourney		Haller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO	217-28-0108	T. Mrs. Robert Nelson, Shaw, W.Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: February 4, 1969

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 7, 1969	I.O.O.F. Cemetery	Elk Garden, Mineral Co. WVa

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Amy Mildred Shaplin	Bla ine, W.Va. P.O. KITZMILLER, MD	FEB 7 1969	Charles Judge

VR A15ME (5)
10M REV. 1/68

1

01817

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01809

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ROBERT	G.	STOVER	02 26 69	A 2:35 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	10-21-15	53 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
PENNSYLVANIA	U.S.A.		ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	PRODUCTION MANAGER	CELANESE CORP

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	316 SUNSET DRIVE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM		STOVER	(BORN) MAE		STOVER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
YES 1940-1952	220-07-6048	SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory failure	2 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Multiple lung metastases	6 months
DUE TO, OR AS A CONSEQUENCE OF (c)	Carcinoma of kidney	18 months

1890

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Paralysis below level of D8

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
11-15-68	Increasing paralysis/legs	YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this haspital) attended the deceased from 11-12-, 1968, to 2-26-, 1969, that (I) (~~we~~) last saw the deceased alive on 2-25-1969, and thot in (my) (our) opinion death occurred on the date and hour and from the couses stoted above, (I) (we) (did) (did nat) view the body ofter deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert Fiddis		[X]	[ ]	[ ]	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R. FEDDIS, M.D.	500 GREENE ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Febr 28 1969	Shrewsbury Luth. Cem.	Shrewsbury York Co. Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James J. Hartenstein	New Freedom, Pa.	MAR 3 1969	Nicholas Judge

VR A15 (4)
45M - 1/69

ROBERT G. STOVER 02 26 69 2:55

MALE WHITE 10-21-15 53

PENNSYLVANIA U.S.A. ALLEGHANY COUNTY,

CUMBERLAND SACRED HEART HOSPITAL PRODUCTION MANAGER CELANESE CORP

MARYLAND ALLEGANY CUMBERLAND X 315 SUNSET DRIVE

WILLIAM STOVER (BORN) MAE STOVER

YES 220-07-5048 SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502

R. FROSIS, M.D. 500 GREENE ST., CUMB., MD. 21502

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01818 — 01810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: WILLIAM	Middle: H.	Last: STUBY	2a. DATE OF DEATH Month: 2	Day: 23	Year: 69
2b. HOUR	12:55 P M					
3. SEX	MALE					
4. RACE	WHITE					
5. DATE OF BIRTH	6-30-1887					
6. AGE (In years last birthday)	81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN			
7a. BIRTHPLACE (State or foreign country)	PENNA.					
7b. CITIZEN OF WHAT COUNTRY?	U. S. A.					
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]						
9. COUNTY OF DEATH	ALLEGANY CO. Md.					
10. CITY OR TOWN OF DEATH	CUMBERLAND					
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	MEMORIAL HOSPITAL					
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	RETIRED					
12b. KIND OF BUSINESS OR INDUSTRY	RR					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	PENNA.					
13b. COUNTY	Bedford					
13c. CITY OR TOWN	HYNDMAN					
13d. INSIDE CITY LIMITS? YES [ ] NO [X]						
13e. STREET AND NUMBER	BOX 121					
14. FATHER'S NAME	First: HENRY	Middle:	Last: STUBY			
15. MOTHER'S MAIDEN NAME	First: MARY	Middle: A.	Last: WOLFORD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	No	(If yes give war or dates of service)				
16b. SOCIAL SECURITY NO.	716-10-2463					
17. INFORMANT	MEMORIAL HOSPITAL	Address				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) myocardial infarction. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF

(b) atherosclerotic heartdisease.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. — 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this haspital) attended the deceased from 2/20, 19 69, to 2/23, 19 69, that (I) (we) last saw the deceased olive on 2/23 19 69, and thot in (my) (aur) opinion deoth occurred on the date and hour and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: George M Simons M.D. — DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [ ] — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): (G) DR. SIMONS — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	Feb. 26, 1969	Lybarger Cemetery	Buffalo Mills, Pa. RD#1	
24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
Harvey H. Zeigler,	Hyndman, Pa.	FEB 26 1969	Eleanor Yeager	

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01819 — 01811

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: CHARLES	Middle: A.	Last: SWAUGER	
2a. DATE OF DEATH	Month: 2	Day: 24	Year: 69	2b. HOUR: 4:08 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 8-20-33	6. AGE (In years last birthday): 35 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.	
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY: NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: MT. SAVAGE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: RT. # 1 BOX 63 21545
14. FATHER'S NAME: First ALBERT	Middle	Last SWAUGER	15. MOTHER'S MAIDEN NAME: First HAZEL	Middle	Last GORDON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-32-4372	17. INFORMANT: HOSPITAL CHART	SACRED HEART HOSPITAL 900 SETON DRIVE CUMB., MD. 21502	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pancreatitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 28 hr –
DUE TO, OR AS A CONSEQUENCE OF
(b): Extensive Abdominal Surgery — 7 days
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5329

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): None

19a. DATE OF OPERATION: 2/13/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Intestinal Duodenal Ulcer	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☒	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 1/29, 1969, to 2/24, 1969, that (I) (we) last saw the deceased alive on 2/24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Martin Rothenstein DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED: 2-24-69			
22d. PHYSICIAN'S NAME (Type): MARTIN M. ROTHENSTEIN M.D.	22e. ADDRESS: 48 BROADWAY ST., FROSTBURG, MD. 21532		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: FEB. 27, 1969	23c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEM. PARK	23d. LOCATION (City or Town) (County) (State): FROSTBURG ALLEGANY, MD.	
24. FUNERAL DIRECTOR: MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG	ADDRESS	25a. RECD BY REGISTRAR: MAR 4 1969	25b. REGISTRAR'S SIGNATURE: Jeanes Judge	

Marilou M. Sowers

VR A15 45M - 1/68

CHARLES A. SAUGER

MALE WHITE 8-20-33 35

MARYLAND USA X ALLEGANY

CUMBERLAND SACRED HEART HOSPITAL NONE NONE

MARYLAND ALLEGANY NT. SAVAGE X NT. R 1 BOX 63 21545

ALBERT SAUGER HAZEL GORDON

NC 220-32-4372 HOSPITAL CHART 900 SETON DRIVE CUMB., MD. 21502
SACRED HEART HOSPITAL

MARTIN M. ROTHBSTEIN 48 BROADWAY ST., EUX FROSTBURG, MD. 21532

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01820 01812

1. DECEASED-NAME (Type or Print) First: Olga	Middle: I.	Last: Swisher	2a. DATE KNOWN OF DEATH ESTIMATED ☐: Month 2 Day 27 Year 1969	2b. HOUR: 2:50 P.M.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Oct. 30, 1892	6. AGE (In years last birthday): 76 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month February Day 27. Year 1969	2d. HOUR: 2:50 P.M.		
7a. BIRTHPLACE (State or foreign country): Michigan	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DOA Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 208 Maryland, Ave.			
14. FATHER'S NAME First: Gustoff	Middle	Last: Kolbe	15. MOTHER'S MAIDEN NAME First: Annamarie	Middle	Last: Brenki		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-18-1385	17. INFORMANT ADDRESS: Earl L. Wilson, 915 Harding Ave., Cumberland, Md					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO, OR AS A CONSEQUENCE OF
(b) CORONARY SCLEROSIS — --
DUE TO, OR AS A CONSEQUENCE OF
(c)

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: February 27, 1969
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	3/2/69	Rose Hill Cemetery	Cumberland, Allegany, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Hafer	230 Balto., Ave., Cumberland, Md.	MAR 3 1969	

VR A15ME (5)
10M REV. 1/68

1

01821

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01813

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: CHARLES	Middle: L.	Last: TALLEY	2a. DATE OF DEATH Month: 2 Day: 5 Year: 69	2b. HOUR: 11:35 A M
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 1-14-07	6. AGE (In years last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Clerk	12b. KIND OF BUSINESS OR INDUSTRY: Groc. Store		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 133 OAK ST.	
14. FATHER'S NAME First: HENRY	Middle:	Last: TALLEY	15. MOTHER'S MAIDEN NAME First: BARBARA	Middle:	Last: GREEN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: yes	(If yes give war or dates of service): War II	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Cardiac Failure	6 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	Emphysema (Severe)	6 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Pulmonary Fibrosis	3 yrs

492X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from June, 19 67, to Feb 5, 19 69, that (I) (we) last saw the deceased alive on Feb 5, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Clark Summitt	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 2/6/69
22d. PHYSICIAN'S NAME (Type): DR. C. DURRETT		22e. ADDRESS: CUMBERLAND, MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Feb. 8, 1969	23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: FEB 10 1969	25b. REGISTRAR'S SIGNATURE: Charles Yuga	

VR A15 (1)
45M - 1-68

50 01 1 1 1 12

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill out Pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01822 — 01814

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF ESTIMATED DEATH	Month Day Year	2b. HOUR
Cora	Alice	Teeter	☒	Feb. 15, 1969	5:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	May 5, 1890	78 YRS.			February 15, 1969 19	5:30 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
West Virginia	U.S.A.	MARRIED ☒	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	DOA Memorial Hospital	Housewife	Self

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Flintstone	YES ☐ NO ☒	Murley's Branch Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James	A.	Shreve	Smildia		Ayers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		220-52-9928	Blaine Teeter, Flintstone, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Cumberland, Maryland

22b. **DATE SIGNED**: February 16, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/18/1969	Glendale Cemetery	Near Flintstone Alleg Md

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr., 230 Balto Ave. Cumberland MD	FEB 19 1969	

2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01823 01815

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: ANNA	Middle: L.	Last: TWIGG	2a. DATE OF DEATH Month: FEBRUARY Day: 4, Year: 1969	2b. HOUR: 5:25 PM	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-18-1903	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY		Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 130 MAPLE ST	
14. FATHER'S NAME First: W. Middle: E. Last: KNIPPENBURG	15. MOTHER'S MAIDEN NAME First: CAROLINE Middle: HANDLE Last:				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 410.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus, NCVD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 1-25, 1969, to 2-4, 1969 that (I) (we) last saw the deceased alive on 2-4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Wilbur P James			[X]		2/6/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W.P. JAMES	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Feb. 7, 1969	Sunset Memorial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Philip E. Wendt 121 Memorial Ave., Cumb., Md.	FEB 10 1969	

VR A15 45M - 1/69

10 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01824 01816

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: SARAH	Middle: M	Last: TWIGG	2a. DATE OF DEATH Month: 2 Day: 3 Year: 69	2b. HOUR: 8:20 AM	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 6-25-91	6. AGE (In years last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FLINTSTONE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: ROUTE 2		
14. FATHER'S NAME First: ANDREW Middle: J. Last: BROTEMARKLE	15. MOTHER'S MAIDEN NAME First: ALLA Middle:	Last: WILSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND OEATH
IMMEDIATE CAUSE (a)	CVA	1 day
DUE TO, OR AS A CONSEQUENCE OF (b)	Arterio Sclerosis	years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost. 2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ORCONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OE OEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, EACTORY, OFFICE BUILOING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** thot (I) (this hospital) ottended the deceased from Jan 3, 19 69 to Feb 3, 19 69, thot (I) (we) lost sow the deceased olive on Feb 3 19 69 ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 2/3/69
22d. PHYSICIAN'S NAME (Type): DR. B. SCHINDLER	22e. ADDRESS: CUMBERLAND, MD.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/ 6/1969	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Near Cumberland, Alleg Md
24. FUNERAL DIRECTOR: Charles E. Hafer	ADDRESS: Charles E. Hafer, 230 Balto.Ave., Cumberland, Md.	25a. RECD BY REGISTRAR DATE: FEB 5 1969	25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01825 01817

1. DECEASED-NAME (Type or print): First MARY Middle A. Last VALENTINE
2a. DATE OF DEATH: Month FEBRUARY Day 20 Year 1969
2b. HOUR: 7:12 PM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: 2-23-1889
6. AGE (In years last birthday): 79 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): PENNA.
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give STREET): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 322 RESERVOIR AVE
14. FATHER'S NAME First WILLIAM Middle Last WRIGHTSON
15. MOTHER'S MAIDEN NAME First LAURA Middle Last TWIGG
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 220-46-5751
17. INFORMANT: MEMORIAL HOSPITAL, Address CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anaemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO, OR AS A CONSEQUENCE OF (b): Right Cerebral Haemorrhage — 1 days
DUE TO, OR AS A CONSEQUENCE OF (c): Hypertensive Decomp — 6 wks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 428X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify thot (I) (this hospital) attended the deceased from June, 1967, to 2/20/, 1969, that (I) (we) last saw the deceased alive an Feb 19__, and that in (my) (our) opinion death occurred on the dote and haur ond from the causes stated obave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Clay E Durrett DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 2/21/69
22d. PHYSICIAN'S NAME (Type): DR. CLAY DURRETT
22e. ADDRESS: 236 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/23/1969
23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
23d. LOCATION (City or Town) (County) (State): Near Cumberland Alleg Md

24. FUNERAL DIRECTOR: Charles E. Hafer ADDRESS: Charles E. Hafer, 230 Balto Ave. Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: FEB 24 1969
25b. REGISTRAR'S SIGNATURE: Charles Jungo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1 4-45M - 1-68

1

FOR STATE HEALTH DEPT.

Items 5&6 Film G410
3/14/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01826 01818

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR
MARGARET	S.	VANDERGRIFT	2	26	1698	8 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
FEMALE	WHITE	JAN. 6, 1907 1909	59 62 YRS.					2	26	1691	P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MD.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	206 PARK STREET	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	206 PARK STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Z.	B.	WEST	MINNIE		SISK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
NO			MRS. DAVID LINN MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY THROMBOSIS	----
DUE TO, OR AS A CONSEQUENCE OF (c)	CORONARY SCLEROSIS	----

4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: FEB. 26, 1969

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D. ADDRESS (Street and No. or R.F.D. No., City or Town, State): RT. 9, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	MAR. 1, 1969	DAVIS MEMORIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	MAR 3 1969	Edwards Yingling

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VR-M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00 01 1 2 2

VR A15ME (5) 10M REV. 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

01827

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01819

1. DECEASED-NAME (Type or Print)	First: George	Middle: Vernon	Last: VanMeter	2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month: Feb. Day: 20, Year: 1969		2b. HOUR: 7:30 A.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: June 28, 1898	6. AGE (In years last birthday): 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: Feb. Day: 20, Year: 19 69		2d. HOUR: 7:30 A.M.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): V. A. Sacred Heart,	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Elect. Truck Opr.	12b. KIND OF BUSINESS OR INDUSTRY: Kelly Tire Co.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. Va.	13b. COUNTY: Mineral	13c. CITY OR TOWN: Ridgeley,	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 15 Mineral St.			
14. FATHER'S NAME First: Isaac	Middle: L.	Last: VanMeter	15. MOTHER'S MAIDEN NAME First: Hannah	Middle: M.	Last: McKenzie		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-07-0431	17. INFORMANT ADDRESS: Mr. A Lee VanMeter 17 Mineral St. Ridgeley, W. Va.					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY THROMBOSIS, LEFT	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS(Street, city, town, or county): Rt. # 9 Cumberland, Md.

22b. DATE SIGNED: Feb. 20, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/22/69	Sunset Memorial Park,	Cumberland, Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George Cumberland, Maryland	FEB 25 1969	J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01828 01820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JOSEPHINE	Middle: E.	Last: WENTLING	2a. DATE OF DEATH Month: FEBRUARY Day: 4, Year: 1969	2b. HOUR: 8:05 M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-13-1918	6. AGE (In years last birthday): 50 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: RT. 2 MESSICK RD.		
14. FATHER'S NAME First: JOHN	Middle: W.	Last: STAFFORD	15. MOTHER'S MAIDEN NAME First: ELSIE	Middle:	Last: MESSICK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, Left Lung with Metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Uncertain
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
1621
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 2-4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Calvin Y. Hadidian DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 2/5/69.		
22d. PHYSICIAN'S NAME (Type): DR. CALVIN HADIDIAN	22e. ADDRESS: 203 GREENE ST., CUMB. MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/7/69	23c. NAME OF CEMETERY OR CREMATORY: Mt Herman Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR ADDRESS: Silcox-Merritt Funeral Service. Cumberland, Md	25a. RECD BY REGISTRAR DATE: FEB 7 1969	25b. REGISTRAR'S SIGNATURE: [illegible]		

VR A15
45M - 1/68

78. 1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01829

CERTIFICATE OF DEATH

01821

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 156 Church St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Md. b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport, Md.
d. STREET ADDRESS: 156 Church St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

00 01 1

3. NAME OF DECEASED (Type or print): First: Nancy Middle: P. Last: Whitworth

4. DATE OF DEATH: Month: Feb. Day: 4 Year: 19 69

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: April 28, 1888

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Allegany - Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel G. Dixon

14. MOTHER'S MAIDEN NAME: Persosha Gregg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No

16. SOCIAL SECURITY NO.: 216-46-7646

17. INFORMANT Address: Horace P. Whitworth Allegany St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: None
DUE TO (b): Anaurysm of Right Carotid Artery — 5 Years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

430.9

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

1

21. I certify that (I) (this hospital) attended the deceased from January 5, 1964 to Feb. 4, 1969, that (I) (we) last saw the deceased alive on Dec 29 1968, and that death occured at 2A M, from the causes and on the date stated above.

22a. SIGNATURE: Paul R Wilson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb. 10, 1969

22c. PHYSICIAN'S NAME (Type): Dr. Paul R. Wilson

22d. ADDRESS: 111 Ashfield St. Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 7, 1969

23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery

23d. LOCATION (City, town or county) (State): Westernport, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: W. Harold Fridlock

ADDRESS: Piedmont, W. Va.

25a. REC'D BY REGISTRAR DATE: FEB 11 1969

25b. REGISTRAR'S SIGNATURE: Allegany County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

01830

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: ELSIE	Middle: ELVA	Last: YATES	2a. DATE OF DEATH: 2 Month 19 Day 69 Year	2b. HOUR: 9:10 P M		
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-4-11	6. AGE (In years last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): MD.	7b. CITIZEN OF WHAT COUNTRY?: US OF A	8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER			
14. FATHER'S NAME First: JOSEPH	Middle	Last: PERDEW	15. MOTHER'S MAIDEN NAME First: (WILT) MAUDE	Middle	Last: PERDEW		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-07-0939	17. INFORMANT: HOSPITAL RECORDS	Address: 900 SETON DR. CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): PULMONARY EMBOLIZATION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b): HASCVD & CHF

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4122

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** thot (I) (this hospitol) attended the deceosed from _____, 19____, to _____, 19____, thot (I) (we) lost saw the deceosed olive an _____ 19____, ond thot in (my) (our) opinion deoth occurred on the date ond haur and from the causes stated obave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: By Matthew L Kauf MD	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type): MATTHEW KAUFFMAN, M.D.	22e. ADDRESS: 912 SETON DR., CUMBERLAND, MD.				

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: FEB. 22, 1969	23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.	
24. FUNERAL DIRECTOR: JOSEPH R. DURST, FROSTBURG, MD. 21532	ADDRESS	25a. REC'D BY REGISTRAR DATE: FEB 24 1969	25b. REGISTRAR'S SIGNATURE	

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MATTHEW KAUFFMAN, M.D. 912 SETON DR., CUMBERLAND, MD.